(10) MENTAL HEALTH AND AGING

WRITINGS IN GERONTOLOGY

ÉCRITS EN GÉRONTOLOGIE

THE NATIONAL ADVISORY COUNCIL ON AGING
LE CONSEIL CONSULTATIF NATIONAL SUR LE TROISIÈME ÂGE

Canada

MENTAL HEALTH AND AGING

March 1991
National Advisory Council on Aging

91-05868/

Information on this report may be obtained from:

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Également disponible en français sous le titre:
«Santé mentale et vieillissement»

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Cat. No. H71-2/1-11-1991E
ISBN 0-662-18626-5

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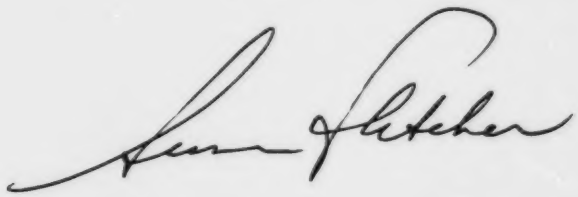
FOREWORD

The *Writings in Gerontology* Series is intended as a vehicule for sharing ideas on topical issues related to the quality of life of seniors and the implications of an aging population. It is produced as part of the National Advisory Council on Aging's mandate to publish and disseminate information and to stimule public discussion about aging.

The Council endeavours to ensure that the articles in the series provide useful and reliable information. Most of the texts are original manuscripts. Some are written by Council staff, others by experts in their fields.

This series is addressed to seniors and the people who care about their well-being. It is hoped that readers will find the *Writings* useful.

The Council welcomes comments on the topics selected as well as on the contents of the articles.



Susan Fletcher
Executive Director
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PREFACE

This series of papers in NACA's *Writings in Gerontology* focuses on the mental health of Canadian seniors, from the perspective of both health and illness. The need for clear and practical information on mental and emotional well-being and on psychological distress or illness became evident during NACA's national consultation on the barriers to independent living faced by seniors. In the two publications (National Advisory Council on Aging, 1989, 1990) presenting the results of this consultation, NACA reported that problems related to emotional and mental well-being were the second most significant obstacle to independent living experienced by community-dwelling seniors. The major difficulties mentioned were loneliness, fear or anxiety, depression and dementia. The majority of seniors reporting emotional or mental problems stated that they handled their problems on their own, without relying on family or friends or professional services.

Through this publication, NACA aims to:

- create awareness about mental health and well-being in aging;
- provide seniors and those caring for elderly persons with information to demystify mental health problems;
- distinguish normal reactions to life stress from abnormal or exaggerated responses; and
- offer suggestions for effective coping.

On behalf of the National Advisory Council on Aging, I thank the contributing authors for their informative and thought-provoking texts.

As well, I thank NACA's staff, in particular, Dr. Louise Plouffe who coordinated the project: determining the content, identifying the authors and organizing the work, and Francine Beauregard and Renée Blanchet, who verified the translation of the texts and edited versions in both languages.

As Chairperson of the Council, I am pleased to be associated with these texts and hope that they will contribute to a better understanding of mental health and illness in later life.

Blossom T. Wigdor

Blossom T. Wigdor, CM, PhD
Chairperson

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INTRODUCTORY CHAPTER

MENTAL HEALTH AND AGING

by

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and
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National Advisory Council on Aging

March 1991
National Advisory Council on Aging

A DEFINITION OF MENTAL HEALTH

Mental health is more than the absence of mental illness; according to Birren and Renner (1980), mental health "also reflects the ability or capacity of an individual to deal with the issues of life in an effective, if not pleasurable or satisfying, manner". Many studies have been conducted to measure the mental well-being of older adults, to examine the various facets of the mentally healthy senior and to determine the conditions that lead to emotional well-being in later life.

It is possible to describe people who enjoy good mental health, who are living a "good old age". Ryff (1987) recently proposed six psychological characteristics of mental well-being. These are: 1) self-acceptance; 2) positive relations with others; 3) autonomy; 4) environmental mastery; 5) purpose in life; and 6) personal growth. These criteria apply to psychologically healthy persons of all ages, but they are especially important for successful aging.

- Self-acceptance means to have a positive, yet realistic, appreciation of oneself.
- To have positive relations with others, one should be able to maintain friendships and intimate relationships, to make new friends, to get along with most people in most social situations and to avoid relationships that are harmful to oneself or to others.
- Autonomy refers to the capacity for self-determination, for resisting pressures to conform blindly to the expectations of others and for evaluating oneself by personal standards.
- To have environmental mastery is to have the feeling that one is basically in control of one's own life and to have confidence that one can effectively cope with setbacks or get through hard times.

- To have a purpose in life means to have goals, a sense of direction and a conviction that one's life is worth living -- regardless of one's physical state or external living conditions. Wong (1989) proposes that, by discovering or creating life-meaning through reminiscence, commitment, personal optimism or religious faith, one can rise above pain, losses and the prospect of death.
- Personal growth refers to the sense of ongoing development and enrichment. A person who is growing psychologically is open to new experiences, new ideas and new skills.

SENIORS' MENTAL HEALTH

In general, seniors seem to enjoy good mental health: many seniors feel at least as content and fulfilled as younger persons. Moreover, as Connidis (1987) found, they actually enjoy some aspects of being older, such as greater freedom from work or family obligations, fewer worries and more time to engage in personal pursuits. A study by Reker (1987) and others showed that older adults have a greater sense of life purpose than do their younger counterparts.

Seniors appear to be saying that they are content if they have the same choices and opportunities as they had in their middle years. This is largely true of younger seniors, who are active and in relatively good health. The well-being of the frail and the very elderly has not been studied well enough to be able to affirm that the average 90 year-old is as content and fulfilled as the typical 65 year-old. Nevertheless, research (Stones & Kozma, 1989) has shown that psychological well-being is fairly robust over time. Contented people remain so for many years: it appears to be in their nature.

Although growing older is actually a more positive experience than it is commonly believed to be (and as the singer Maurice Chevalier once quipped, "old age is better than the alternative"), there are changes and challenges specific to later life: retirement, widowhood, reduced income, physical problems, activity restrictions, loss of friends and loss of familiar surroundings and independent lifestyle if one is institutionalized.

Change, and consequently, stress, are part of life at all ages; in the latter part of life, one frequently has to deal with more change at a time when there is less resistance to stress, but also when there is less preparation and fewer guidelines to successful adaptation. Seniors who adjust well to important life changes display more effective ways of coping than seniors who do not adapt successfully. Typically, they have adjusted well in the past and expect to have to adapt to changes in the future. Those who adjust well may seek the information they need to resolve a specific problem, engage in emotionally and socially uplifting activities to ward off negative feelings, give themselves encouragement when they feel "blue" or draw strength from adversity. People who cope in maladaptive ways will, for example, blame others for their troubles, withdraw from social contacts or escape by over-sleeping, drinking alcohol or watching television excessively. Effective coping strategies are part of a person's repertory of life skills and, fortunately, they can be learned at any age.

MENTAL HEALTH PROMOTION

An individual's personality make-up, attitudes and ways of coping with stress are undoubtedly essential to maintaining good mental health. That is why counsellors and therapists work with people in emotional distress to help them express and resolve their psychological pain or change self-destructive

ways of thinking and behaving. Nevertheless, it is evident that certain life conditions are more conducive to mental well-being than others. However, even the most favourable conditions cannot automatically make a person happy, but they can make it much easier to be happy.

Two persistent factors related to mental health are physical health and financial security. Poor health and poverty often lead to increased worries, restriction of activities, inadequate living conditions and isolation from other people. Older women are somewhat more disadvantaged than men on both counts: women are more likely than men to suffer from long-term, disabling illnesses as they advance in age and they are at greatest risk for poverty, especially if they are widowed, divorced or single.

Marital status and family and friendship ties are also important to mental health. Married seniors of both sexes report higher levels of happiness than unattached (single, widowed, separated or divorced) seniors. Having satisfying give-and-take relationships with other people, and especially a confidant to whom one can confide private feelings, contribute substantially to the sense of well-being. The supportive presence of other people can act as a "buffer" that reduces the impact of stress, or as a "booster" that reinforces one's capacity to deal with stress. A report by Stone (1989) shows that seniors over age 80 who live alone (mostly women) have fewer potentially supportive social relations than all groups of younger persons. In this group of elderly seniors, about 35 percent have no more than one family member or friend on whom to rely.

Other factors that influence the likelihood of enjoying good mental health are worth noting. These include availability and access to meaningful activities and living conditions that are comfortable, pleasant and safe. Belonging to an

ethnic minority group can have a further impact, either positive or negative, on the mental well-being of seniors.

THE INCIDENCE OF MENTAL DISORDERS AMONG SENIORS

The incidence of mental illness is no greater among seniors than among other age groups; in fact, the prevalence of mental disorders not due to brain disease generally decreases after age 45 (D'Arcy, 1987). More specific statistics on the rates of particular diagnostic categories for adults over 45 show that diagnoses of many forms of mental disorder decrease with increasing age. There are far fewer men with criminal personalities in the senior population; these men may die sooner and more violent deaths, they may be imprisoned or their criminal tendencies may abate with age. Another piece of good news is that the differences found between younger men and women with respect to disorders such as depression and anxiety virtually disappear among older age groups, mainly because of the declining rates of these illnesses among older women (George, 1990)[1].

The evidence is not all positive, however. The incidence of Alzheimer's disease and other incurable organic brain impairments increases dramatically with age. The suicide rate, which is much higher among men of all ages than among women, has been increasing in recent years among men over 75. More senior women use mood-altering drugs, such as minor tranquillizers and sedatives, than does any other group in Canada. Seniors who do report

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1. Nevertheless, considering that older women are more likely to experience chronic health problems and low income which are risk factors for mental problems, the findings that senior women do not suffer from more mental health problems than men are perplexing. As George indicates, more research on the effects of gender, health and income on the mental health of senior men and women is required.

symptoms of anxiety or depression experience this distress more frequently than younger persons do. The mental health problems experienced by aging mentally retarded adults and by immigrant seniors demand attention. It is clear that there still are challenges to meet to improve the mental health of Canadian seniors.

CONCLUSION

There are ways to maintain or to improve personal well-being. However, some problems may require assistance from other sources, including peer-counselling, support groups, professional treatment or medication. Severe mental illness, such as dementia in the later stages, may require institutional care.

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DEPRESSION, LONELINESS AND GRIEF AMONG THE ELDERLY

by

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March 1991
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INTRODUCTION

What is depression? What is the difference between depression and sadness? Is depression more prevalent among seniors? What are the treatments offered? How can I help myself? Is the feeling of loneliness more frequent among seniors than in other age groups? Who are the individuals most at risk? Does depression necessarily come with grief?

Here are a few questions we will try to answer in this chapter, keeping a perspective that takes into account the continuity of life experiences and the challenges that are relevant to late adulthood.

1. DEPRESSION

1.1 The Prevalence of Depression among the Elderly

There is a common--and erroneous--belief that problems of psychological distress, depression in particular, are more frequent among the elderly than in the rest of the population (Cappeliez, 1988). Aging and mental deterioration are even considered to be irrevocably linked. As a result, depression is seen as part of the normal aging process[1].

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1. Available research indicate that 20 to 25% of the elderly seems to experience dysphoria (for example, feelings of general dissatisfaction, sullenness, pessimism) to a varying degree. Approximately half of the cases (10 to 15% of the total senior population) present more moderate to severe symptoms of depression. Among this last group, half of the people (5 to 8% of the total senior population) suffer from clinical depression, a term coined to define depression as its meets the criteria of psychiatric diagnostic.

   (Cappeliez, Letter to the Editor, *Canadian Journal on Aging*).

Research carried out in various countries, however, does not support this pessimistic portrait. A recent critical overview of such research (Feinson, 1989; Newmann, 1989) indicates that the proportion of seniors who suffer from "clinical depression" is not higher than it is among their younger counterparts. Certain studies (Bland et al., 1988; Myers et al., 1984) have even reported that younger age groups, particularly the 25-44, have shown higher depression rates, that is approximately 10 per cent, compared to approximately 5 per cent among the 65+. The data have been subjected to several interpretation and methodological critiques (Cappeliez, 1988; Newmann, 1989), but the studies at least have the merit of challenging the idea that aging necessarily involves depression.

It is therefore vital to consider the symptoms of depression expressed by a senior as just that, the signs of emotional distress requiring help. We must not be too hasty in seeing the symptoms of depression as inevitable characteristics of aging. On the other hand, we must not neglect seniors who are indeed victims of depression because we know that the prevalence of depression does not increase with age.

1.2 The Symptoms

The term "depression" is used to describe a number of conditions. It is commonly used to describe a negative change in mood, one that is temporary and fairly mild. This is often an everyday adaptive reaction to loss, one that tends to dissipate with time, leaving little, if any, serious or lasting consequences on the person's activities. On the other hand, depression can take a more serious form, what mental health professionals call "clinical depression". The symptoms are more serious and tend to persist. Table 1 presents these symptoms.

TABLE 1 - THE SYMPTOMS		
1	Changes in behaviour	• general sluggishness (or agitation) • loss of interest and pleasure in activities that used to provide some • withdrawal, decrease in social activities
2	Emotional changes	• acute sadness or feeling of emptiness • demoralization, despair • irritability • anxiety
3	Cognitive changes	• concentration difficulties and memory loss • self-criticism, self-depreciation • suicidal thoughts
4	Physical changes	• sleep disorders such as insomnia, abnormal early waking and others • chronic fatigue, lack of energy • lack of interest in sexual activity • physical discomfort such as constipation, headaches and others

1.3 The Causes

Depression is a complex phenomenon with multiple potential causes. It is clear that depression generally occurs after the loss of a loved one, or the loss of certain capacities or roles. It is also obvious that all individuals who experience loss will not necessarily suffer from depression. However, where the elderly are concerned, the loss of a social role is one variable which should not be ignored.

Research in recent decades has identified some factors which make some people more vulnerable to depression than others. One of them is a cerebral biochemical imbalance, which influences mood and which may be genetically

transmitted. Depression would seemingly result from the activation of this imbalance. It is believed that the physical symptoms of depression, particularly sleep disturbances and decreased appetite and energy, might be caused by this imbalance.

Certain personality types are more vulnerable to depression than others. People who are very hard on themselves, very self-critical, and those who are abnormally passive and dependent, are more liable to depression.

Another risk factor is the inability to form and maintain satisfactory social relationships. People who have been subjected to emotional neglect, abandonment, or physical and psychological abuse from an early age are also more vulnerable.

Health is an important predictor of depression in the elderly (Cappeliez, 1988; McNeil & Harsany, 1989). Health problems, and resulting limitations and problems, seem to play a major role in triggering depression in the elderly. Illness, in addition to its purely physical consequences, can influence the emergence of depression by interfering with the sources of self-actualization and self-esteem, since illness limits activities and social relationships and reduces the individual's feeling of control and independence.

1.4 Treating Depression

Age has no bearing on the range of treatments available. Physical interventions, whether anti-depressant medication or electroshock therapy, are used on seniors with a similar success rate, approximately 60 per cent, to that obtained with other age groups (Meyers & Alexopoulous, 1988; Rockwell et al., 1988).

Despite the common use of a type of psychological intervention called "support therapy", psychotherapies with a specific goal have been used very little with depressed seniors. Recent studies document the effectiveness of such therapies (Beutler et al., 1987; Gallagher-Thompson et al., 1987; Thompson et al., 1987).

Cognitive, behavioral and psychodynamic psychotherapies, either with individuals or groups, have proven effective with seniors. The aim of **cognitive therapy** is to assist depressed persons in identifying and testing the negative views they have of themselves, the future and the world, and to examine the attitudes and beliefs on which their feelings of self-worth are based (Cappeliez, 1986). **Behavioral therapy** seeks to convince people to step up their level of activity and to develop better coping skills, particularly social skills. **Psychodynamic therapy** is aimed at modifying the personality structure with a view to facilitating functioning. It generally involves recognition and alteration of the defence mechanisms. More research on other types of therapy are expected as well as the pursuit of more detailed studies of the mechanisms responsible for therapeutic changes.

On the other hand, 40 per cent of depressed people do not receive the success they expected from the different treatments. We must also take into account all the seniors who do not seek professional help even though their condition would justify it. A great deal remains to be done to reach seniors who are most in need of assistance and to improve the treatment efficiency.

1.5 What Can One Do to Help Oneself?

Physical and social activities are important.

> Both physical and social activity promote competence and have preventative remedial effects on stress reactions and illness. Physical exercise encompasses a generalized "tonic" [...] and promotes and maintains good health [...]. Social activity not only provides intellectual stimulation, but locates the individual in a social support network that helps reduce the impact of morbidity. (Stones & Kozma, p. 533).

Social support is also important in overcoming depression. The positive effects of social relationships go beyond the realm of depression. It is a known fact that people with broad social networks enjoy better physical and mental health (House et al., 1988). It seems that having an intimate relationship is particularly important in fighting depression. An elderly person who shares his or her concerns with a spouse or partner will cope better with depression.

Certain personality traits help cope better. People who seek solutions to problems are more resistant to depression than those who tend to control their emotions. As well, those with an "internal focus of control" cope with depression better than those with an "external focus of control" (this refers to the control one attributes to oneself as compared to the control one attributes to other people or to events).

Keeping an open mind about life experiences seems to be an important coping strategy to counteract depression and the tendency to close in on oneself.

As Wong (1989) pointed out, the significance a person attaches to his or her own existence contributes not only to the promotion of health but also to the maintenance of morale in times of difficulty and illness. The significance one attributes to one's own existence can take many forms. Religion, spiritual

growth, assumption of social responsibilities and the pursuit of ideals are but a few examples. There are obvious links with the traits we have already mentioned, including having an open mind and being socially involved. This is where the challenge lies: to create meaningful social roles for the individual during the mature years.

Psychologists from the various schools of thought all agree that one essential factor in adapting to aging is the significance the individual attaches to aging. The perception we have of our own aging is linked to the balance we are able to establish between what we want and what we have. Consequently, if we find aging difficult, it is possible to improve our lives by establishing a better balance between our expectations and reality. This balance is more easily attainable if we stay active and develop realistic expectations of what we can do.

- It is beneficial to make new acquaintances. Isolation increases vulnerability to depression. We all need others with whom to exchange views, discuss our opinions and to feel useful to society.
- It is important to develop and pursue activities we like, particularly ones that put us in contact with others.
- To make our own decisions is also important. Too often, seniors let others decide for them. Often, good decisions can be made after gathering new information and opinions from others.
- It is a good thing to take risks and to try new things, without necessarily expecting to be successful immediately. If we restrict ourselves to what is familiar, our lives become narrower and narrower, and more tedious.

- We must not be afraid to ask for help. We sometimes hesitate to call for help when things are not going right; we don't want to be a burden, and we don't want to cause trouble. We feel we have no right to ask, or that help is not available or difficult to get. Many seniors refuse to ask for help out of fear that they will be considered crazy or incompetent. Once we have overcome that obstacle and do get help, we realize on the contrary, that asking for help is a sign of health and maturity, a way of being in control.

2. LONELINESS

2.1 The Prevalence of Loneliness among the Elderly

In the most advanced stages of adult life, many are confronted with a series of events that can lead to isolation, among them the death of their spouse, friends or acquaintances, geographical separation from their children, and the appearance of physical handicaps that limit mobility. It could therefore be expected that feelings of loneliness in this segment of the population is more prevalent. However, studies (De Grâce et al., 1987) disprove this.

A limited number of seniors do report feelings of loneliness, but comparisons with other age groups indicate that the elderly suffer less often from loneliness than do younger people. The contrast with adolescents is particularly striking. This phenomenon is attributable to the difference between social isolation (an objective reality) and loneliness (a subjective feeling). Loneliness may be defined as **a state of dissatisfaction** with the quantity and quality of interpersonal relationships.

The problem of loneliness, therefore, may perhaps not be as widespread as one might think. Nevertheless, some seniors do suffer a great deal from loneliness, and it is important to identify those at risk.

2.2 Profile of Individuals at Risk

It does not appear that factors such as age, sex, level of education or income predispose loneliness. The type of accommodation (private home, institution, seniors' building) does not seem to be a factor either. The degree of dissatisfaction with one's accommodation, however, can be important. Similarly, the number of activities does not seem to affect the level of loneliness, but dissatisfaction with the quantity and type of activities can play a role. Generally speaking, widows and widowers suffer more from loneliness than married people. This is particularly true in the first few years following the spouse's death; for most people the feelings of loneliness decrease gradually thereafter. Factors such as hearing problems, physical limitations and negative perceptions of one's health are more likely to cause feelings of loneliness. Loneliness may also be associated with social anxiety and poor social skills.

No one will be surprised to hear that people who feel lonely derive less satisfaction from life than others. They also show more signs of depression and negative feelings of boredom and uselessness.

2.3 To Help Oneself: Friends and Family

The importance of relationships with friends in counteracting the feeling of loneliness is worthy of note. According to a Canada-U.S. study (Larson, et al.), it seems that contacts with friends are more important than with family for feelings of self-worth and belonging, as well as for the promotion of emotional

exchanges. The authors suggest that friends serve to re-affirm one's sense of identity and of belonging to the community, and provide a source of enjoyment in a situation of openness and reciprocity.

Furthermore, activities with friends are perceived as being more interesting because they are more varied than those performed with family. In fact, interactions with family members are perceived as being sterile, rigid and ritualized.

Finally, the key factor is not social isolation as a physical phenomenon, but rather the absence of a person with whom one can share at the emotional level. This makes it understandable that seniors living with strangers with whom they have no emotional ties will be more likely to suffer from loneliness and depression than do seniors living alone.

3. GRIEF

3.1 The Probability of Grief

The subject of grief is very complex. It is obvious, however, that as we get older, grief, particularly the loss of a spouse or friends of the same age, is experienced by an increasing number of individuals. Increased frequency of grief does not necessarily mean increased psychological distress. According to some authors, such as Neugarten (1970), some losses may be better tolerated by seniors because they occur at a point in their lives when such losses can be expected.

3.2 The Experience of Grief

Naturally, a person who has suffered a loss needs time to adapt. For seniors as for others, the "normal" mourning period can be characterized by feelings of distress and dissatisfaction, weeping and even sleep disturbances. They are physical, emotional and intellectual adjustments to the loss of a loved one, and they overlap with some of the symptoms of depression previously described. Unlike depression, however, "normal" grief is not generally characterized by feelings of lowered self-worth. Various authors have proposed a temporal schema of the different phases of grief (Table 2).

In addition, since grief is not experienced in the same way by everyone, care must be taken not to consider these phases as necessary steps. When they do occur, their sequence and intensity are not uniform either. This is merely a model for an understanding of the grief and mourning process. Even when the mourner resumes normal activities after a few days, moments of great sadness reoccur for many weeks and months. Over time, these moments decrease in intensity and in frequency.

According to Wisocki and Averill's synthesis (1987), the grief that seniors experience may differ from that of a younger person. They may experience more physical symptoms such as pain and gastro-intestinal complaints than does a younger counterpart. There may be more of a tendency toward isolation and apathy. When there is difficulty coping with grief, this may be characterized by conflicting thoughts and feelings of lessened self-worth, despair, guilt and anger.

TABLE 2 - PHASES OF GRIEF		
1	Shock	• Feeling of being cut from the rest of the world • Feeling of numbness and irritability
2	Anger and pain due to the separation	• Strong pain often accompanied by restlessness when the mourner feels the "presence" (i.e. memories, dreams) of the deceased person, and rebellion against the loss
3	Disorganization and despair	• Loss is accepted but a feeling of bitterness appears • Apathy and withdrawal, loss of appetite and sleep disorders can appear with conflicting feelings of irritability, shame, anger and despair
4	Detachment and reorganization	• Integration of the loss into new beginnings • Development of a new way of looking at the world and at oneself • Adjustments to daily life • Creation of new life goals and return of hope

3.3 The Effects of Grief

It is easy for an uninformed observer to underestimate the time it takes for a person to get over his or her grief.

The effects of grief on physical and mental health are the subject of argument (Wisocki & Averill, 1987). Some studies report an increase in

mortality rates or illness among people who recently have suffered a loss. Other studies have found no significant differences in health indices. However, it is widely recognized that loss represents a major stress and that it causes significant modifications in the mourner's lifestyle (i.e. financial resources, change of residence, new or added responsibilities). Recent research considers that the consequences of grief, either direct or indirect, have an impact on physical and mental health.

Again it appears that the support of friends and family is particularly important. Those close to the grieving individual should allow him or her to express sadness for a while until he or she comes to grips with it, and the individual should then be encouraged to resume activities gradually and build a new life without the deceased loved one (Gauthier & Marshall, 1977). Self-help groups of people who have gone through, or are going through, the same experience may prove very helpful as well.

CONCLUSION

This presentation opens up a positive perspective of mental health for seniors. It seems that the difficulties discussed here are not as widespread or as severe as is usually believed. Efficient interventions are available for those whose personal coping capacities are insufficient.

Despite this reassuring vision, we have to remain realistic. A number of seniors have more difficulties than the average in coping with depression, loneliness and grief. It is for these seniors that it is important to improve our prevention and intervention strategies, especially in making the services more available.

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CONFUSION AND DEMENTIA IN THE ELDERLY

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March 1991
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INTRODUCTION

The dementias are a group of illnesses whose hallmark is progressive mental deterioration, often referred to as "cognitive impairment". Cognitive impairment implies a loss of previous mental abilities, such as attention, concentration, orientation and memory. The memory problems associated with dementia are much more serious than the benign forgetfulness that can occur occasionally at any age but which may be more common in the elderly. Normal forgetfulness can be annoying at times, but it does not impair functioning to the extent caused by the mental (or cognitive) deficits related to dementia.

Impairment of functioning refers to a change in social or occupational functioning or a reduced ability to perform everyday activities such as dressing, washing and feeding oneself. The inability to perform such activities significantly impairs a person's ability to live independently. Besides the mental deterioration and impaired functioning, people with dementia can display a wide variety of troublesome behavioral disturbances such as agitation, hallucinations, paranoia and depression (Ropper, 1979).

It was previously thought that dementia was caused by "hardening of the arteries". In fact, dementia can result from several distinct diseases affecting the brain, although Alzheimer's disease is the most well-known and the most common form of dementia. Diagnosis depends to a great extent upon the medical history of the person and the pattern of symptoms exhibited. A few of these dementias are potentially reversible (curable) if the underlying problem is corrected.

Dementia represents a serious health problem in Canada and elsewhere. Between 5 to 10 per cent of people aged 65+ and 20 per cent of the 80+ suffer

from some form of this illness (Jenike, 1986). These figures, which demonstrate how the risk of developing dementia increases with aging are probably underestimated (Evans et al, 1989; Jeans et al, 1987). In nursing homes and in homes for the aged, the prevalence of dementia often exceeds 50 per cent. The impact of dementia on public health also extends beyond the immediate victims to the families who care for the victims (Rabins, 1988).

This paper discusses briefly Alzheimer's disease, other dementias and delirium. It also looks at various aspects in how to care for a person with dementia.

1. ALZHEIMER'S DISEASE

Mr. A., an 80 year old-man, lived in a home with his wife. Over a period of five years, he had become progressively more forgetful and required increased assistance with everyday tasks such as dressing, washing and feeding himself. He could not recognize his grandchildren, did not know what year it was, and would often have problems finding the correct words to express himself. He was examined by a physician who diagnosed Alzheimer's disease and suggested to the wife that she consider placing him in a nursing home, which she refused. When she became ill and was hospitalized, Mr. A. moved in with his daughter. Following this move he was more confused and agitated, and often accused his daughter of stealing his money.

Approximately 50 per cent of people who develop dementia will have Alzheimer's disease, also known as senile dementia of the Alzheimer type (SDAT). This is a progressive illness which usually begins in mid- to late life and becomes increasingly common with aging. Although variable, the disease usually progresses through a number of stages (Raskind, 1989).

Initially, the person may have problems with short-term memory, forgetting names or misplacing belongings. It is often extremely difficult to distinguish what is "normal" from what is "disease" at this stage. There may be difficulties with speech such as frequently searching for the correct word, or problems naming common objects. At this stage the person may be aware of the impairment and become socially withdrawn or depressed.

In the next stages memory problems become more severe: the person loses track of time and may not recognize his or her surroundings; speech may become increasingly incoherent and comprehension is impaired; there may be loss of ability to use common objects or perform common tasks; insight and awareness are usually lost at this stage and behaviours such as wandering, agitation, hallucinations and paranoia become more common.

In the final stages the individual often becomes bedridden and totally dependent on caregivers. Speech, if present, is garbled and incomprehensible. Finally, death will result from physical deterioration and infections such as pneumonia.

There are currently no tests or X-rays that can identify Alzheimer's disease as the specific cause of dementia. The diagnosis is made by the physician based on history and physical examination, and after other identifiable causes of dementia have been ruled out. Most people with Alzheimer's disease die within 5 to 10 years after the diagnosis is made. A definite diagnosis of Alzheimer's disease can only be made at autopsy when microscopic examination of brain tissue reveals the characteristic pathology of the illness (Raskind, 1989).

The cause of Alzheimer's disease is not known, although there are many hypotheses that are being investigated. At least one sub-type may be an inherited illness; however, there is much less evidence of heritability in most cases of the illness. Some investigators have suggested a genetic hypothesis based on the findings that most people with Down's syndrome who live long enough eventually develop the characteristic pathology of Alzheimer's disease (Kay, 1989). The accumulation of aluminium or other environmental toxins in the brain and certain viruses have also been linked to the development of the illness.

2. OTHER DEMENTIAS

Although Alzheimer's disease is the most common type of dementia, there are many others. Dementia caused by repeated small strokes (referred to as multi-infarct dementia) is the second most common type, followed by chronic alcohol abuse (Korsakoff's disease) and certain neurological illnesses such as Parkinson's disease, Huntington's disease and multiple sclerosis. As short listing of the causes of dementia is as follows:

- Alzheimer's disease
- Multi-infarct dementia
- Alcoholic dementia
- Pick's disease
- Normal pressure hydrocephalus
- Dementia associated with thyroid disease
- Dementia associated with neurological illnesses (e.g. Parkinson's disease, multiple sclerosis)
- Dementia associated with infections (e.g. syphilis)

- Dementia associated with brain tumours
- Dementia associated with head trauma

The fact that many physical conditions can produce the symptoms of dementia, and that some of these conditions are potentially reversible if detected soon enough, underscores the importance of a thorough physical, neurological and psychological assessment. For example, the cognitive impairment occasionally associated with thyroid disease or with vitamin deficiency can be stopped and possibly reversed if the underlying problem is corrected.

Some psychiatric disorders, most notably depression, also can cause symptoms that are difficult to distinguish from dementia. The dementia syndrome of depression, referred to as "depressive pseudodementia" does have some clinical features that can differentiate it from true dementia (LaRue et al, 1985); moreover, when the depression is adequately treated (see article in this publication by Cappeliez), mental functioning returns to normal. The importance of a thorough psychogeriatric assessment is again emphasized.

3. DELIRIUM

Delirium is another relatively common and reversible form of illness among older persons. Typically, symptoms of confusion, cognitive impairment and behavioral disturbances (Lipowski, 1989) develop abruptly, usually within hours or days, and may fluctuate often; often the symptoms are much worse at night. There is always impairment of attention and concentration. Orientation, short-term memory, language and other cognitive functions are often impaired as well. The person may appear and feel as if in a dreamlike state, and hallucinations, illusions and delusions of persecution are common.

Because delirium and dementia share common features, it is sometimes hard to differentiate between the two syndromes. Nevertheless, it is extremely important to recognize delirium because it often heralds the onset of physical illness. Since almost any physical illness can precipitate delirium in seniors, any illness should be considered a medical emergency requiring immediate medical attention and possibly hospitalization. The causes of delirium include the following:

- illnesses which directly affect the brain (e.g. stroke, tumour, infection);
- illnesses which affect the kidney, the liver and the heart;
- bacterial and viral infections;
- over-the-counter and prescription medications, and
- withdrawal from alcohol, barbiturates and other sedatives.

Unlike dementia, the duration of delirium is usually brief, lasting less than one month, and symptoms subside when the underlying medical problem is treated. During the acute period of delirium, the person requires close observation, an environment that avoids over- and under-stimulation and sedatives to provide relief.

4. CARING FOR THE PERSON WITH DEMENTIA

4.1 Accurate Diagnosis

The first step in caring for the person with dementia is to ensure that an accurate diagnosis has been made. By investigating the life history, performing a physical examination and ordering a number of lab tests, the physician will be able to rule out most of the potentially reversible dementias and identify

other physical illness which may worsen the problem. Occasionally a physician will order a CT scan of the head, or suggest consultation with a neurologist, a psychologist or a psychiatrist.

4.2 Goals and Expectations

Should the examination reveal a progressive irreversible dementia like Alzheimer's disease, it is important for the caregiver to set realistic goals and have reasonable expectations. The primary goal should be to help the individual function at the highest level physically, emotionally and intellectually for as long as possible. Expectations should depend upon the person's level of cognitive functioning and should be set neither too high nor too low. The caregiver must always be aware that the disruptive or bizarre behaviours associated with the illness are a direct expression of the underlying brain disease; this will prevent behaviour like screaming or wandering being labelled by the caregiver as "manipulative" and "attention-seeking", or behaviours like agitation and aggression being labelled as the actions of a "bad" person.

An important expectation is that the disease will progress and the symptoms will become worse. This implies the need to plan for the future.

4.3 Planning: Using "The System"

Most caregivers are unfamiliar with the many aspects of care that need to be considered. Therefore, building a network of support and using available components of the community health system is essential. A caring, involved family physician is often the best person to act as a case manager and help the family co-ordinate medical and psychosocial interventions. Social workers can

help with the mobilization of home-care services, referrals to day programs and, ultimately, with applications for long-term care institutions. Family, friends, other physicians, visiting nurses, community occupational therapists, lawyers and clergy may all be necessary at different stages. The Alzheimer Society of Canada is an excellent resource which provides information about the disease and available services and which offers moral support to help families coping with irreversible dementia. Similar associations exist for related diseases that lead to dementia, such as the MS Society.

Often overlooked when planning for the need of the person with dementia are finances (Overman & Stoudemire, 1988). Caregivers should seek advice from doctors and lawyers about enduring power of attorney, guardianship, trusteeship and other financial considerations as soon as possible (National Advisory Council on Aging, 1991). Planning can save caregivers time, money and frustrations if the patient is declared mentally incompetent at a later stage.

4.4 Medical Treatment

At present a diagnosis of Alzheimer's disease or of another degenerative dementia implies that the cognitive impairment is progressive and irreversible. There are currently no medications that significantly improve memory impairment or any other cognitive deficit (Jenike, 1986). Medical management is therefore aimed at monitoring and treating intercurrent medical and psychiatric illness. Even minor illnesses such as bladder infection or the flu may precipitate delirium in a person with dementia and lead to a significant worsening of confusion and impaired functioning.

Depression, hallucinations, delusions and agitation are common symptoms that may require treatment (Reisberg et al., 1987). Although it is unclear which is the best form of treatment, depression in dementia responds well to medication (anti-depressants) and psychosocial interventions. Psychotic symptoms such as hallucinations and delusions often respond to medications called neuroleptic, although these drugs can cause numerous side-effects in the demented elderly. Agitation is an extremely common and difficult problem to treat. It requires environmental changes, behavioral or psychological interventions and the use of medications. The use of any psychoactive medication should be monitored closely and continuously reassessed as the risk of adverse reactions is increased by advanced age and underlying brain disease.

4.5 Where to Care

Until several years ago, caregivers of people with dementia had only two choices: to care for the person at home on their own, with little external support, or to admit the person to a long-term care facility such as a nursing home or home for the aged.

Today, in many centres, there are more choices: community agencies can supply homemakers, visiting nurses, social workers and occupational therapists. There are day programs which provide recreation and psychosocial activities. Some hospitals run day hospitals where cognitively impaired people with other medical problems in need of rehabilitation can attend. Others provide respite care or intermittent admission programs, admitting the demented person for several weeks to temporarily relieve the caregiver.

For that person, one of the most difficult decision to make is deciding if and when institutionalization is necessary. Many factors complicate this decision, including the degree of impairment and the type of behavioral disturbances displayed by the demented person, his or her physical and emotional abilities, as well as the availability of community services and long-term care beds. The wishes and desires of the demented person and the caregiver are other important considerations.

Regardless of the process or outcome of this decision, early and long-term planning is essential. Too often these decisions are avoided until there is an acute crisis and the person requires emergency admission to a general hospital. This often leads to a marked increase in confusion, disorientation, agitation and impairment of functioning, as well as needlessly delaying the admission to long-term care.

4.6 Caregiver Support

Providing care for someone with a progressive dementing illness leads to a kaleidoscope of emotions: sadness, anger, frustration, hopelessness, guilt, as well as joy and pride. Caregiving can be extremely stressful physically, emotionally, socially and financially (Rabins et al., 1982). Although many caregivers cope remarkably well with stress, others experience "burnout" and can become depressed or physically ill. Ideally, the burden of care should not fall on the shoulders of a single person, but should be shared as much as possible with other family members or friends. Unfortunately, a common complaint is that the process of caregiving often results in isolation and loneliness.

Caregiver support groups run by local hospitals, community agencies and the Alzheimer Society are excellent forums for ventilation, support and education. When a group of people caring for individuals get together, there is always a sharing of problems and solutions which can be invaluable.

Finally, just knowing that there are others out there dealing with the same kind of problems can help many caregivers cope.

CONCLUSION

Much has been learned about Alzheimer's disease and related disorders in the past decade. Unfortunately, until treatments are developed to prevent, stop or reverse the mental deterioration, dementia illnesses will continue to put increasing demands on society as our population grows older. More public attention and funds will be required to help caregivers cope with this tremendous burden. Recent developments in the understanding of brain structure and function may, in time, lead to interventions which will relieve the suffering of affected seniors and lift the burden from the shoulders of their family.

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FEAR AND ANXIETY IN THE ELDERLY

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March 1991
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INTRODUCTION

Aging is associated with physiological, psychological and social changes in the individual. Although these changes reflect the aging process in a given society and are in no way abnormal, some may disrupt the individual's life and thus affect his or her physical and psychological condition. For example, retirement in a society where work is highly valued, or widowhood when it threatens financial security, may cause adjustment problems. However, as in any transition, the ability to adapt varies from one individual to another. These differences depend on socio-economic conditions, gender, and other personal factors. Nevertheless, apart from the objective situation, individual emotions and attitudes are predominant in the way one may react. Some reactions to change, initially justified, may degenerate into chronic, paralyzing, psychological distress. It is therefore essential to separate normal reactions from the abnormal.

Fear and anxiety are instinctive mechanisms which humans have always experienced. Originally, the level of intense alertness triggered by various physiological reactions was needed to react to imminent dangers, the so-called "fight or flight" reaction. Today, life is not totally free of threats, but they rarely put people's lives in immediate danger. Only rarely is it necessary to fight or run away. Nevertheless, fear and anxiety in the face of situations perceived to be threatening continue to put our bodies on the alert.

This discussion is focused exclusively on reactive anxiety, which is linked to individual experience, as opposed to clinical anxiety, which is connected to psychiatric problems such as phobias and panic attacks. The most common type of anxiety among seniors falls in the first category, which is a feeling of anguish rooted in the individual's experiences and shaped by his or her way of reacting to life circumstances. Thus, anyone is likely to be exposed to anxiety.

It is therefore important to examine the phenomenon in detail, the forms it takes in our everyday lives, its consequences and how to find a remedy for it.

1. FEARS AND ANXIETY

1.1 Nature and Prevalence

Fear is evoked by a concrete threat that the person can readily describe. For example, one could have a legitimate fear of driving a car in bad weather or of walking on icy sidewalks. Anxiety is a continuation of the fear response, except that the precise cause is more difficult to pinpoint. The anxious person anticipates a vague threat, more or less grounded in reality; he or she feels internal distress accompanied by symptoms such as aching muscles, the sensation of a lump in the throat, trouble in catching one's breath, sleeping disorders and trouble in concentrating.

At a moderate level, anxiety may be a force that triggers action and adjustment to the challenges brought about by life transitions; however, if the anxiety is very intense or lasts a long time without resolution, the person can be emotionally harmed. Fears and anxiety are unhealthy to the extent that they interfere with normal activities and harm social relations.

About 10% of senior women and 5% of senior men suffer from serious anxiety disorders (Gurland & Meyers, 1986); in fact, middle-aged adults report more symptoms of anxiety than do seniors (D'Arcy, 1987). According to several experts, common fears expressed by seniors include: fear of becoming dependent, of becoming senile and being institutionalized, fear of crime and of accidents (e.g., falls), fear of abandonment and of social isolation. Butler and Lewis (1982) state:

> "The sense of free-floating anxiety intensifies in older people as illness and imminent death undermine illusions of invulnerability built up as a protection during a lifetime". (p. 54)

It must be noted however, that the awareness of one's increasing vulnerability does not evoke the same degree of anxiety in all older adults. The most elderly seniors (75+ years old) seem to be less afraid of death than do younger seniors. At this age, people are generally less anxious about everything, as if time had inoculated them against stress.

1.2 The Physiological Aspect: What Is Felt

Aging is associated with a reduction of the central nervous system's ability to regulate itself. Reaction time to stress is slower, and it takes longer to recover once the reaction has been triggered. The reaction itself is stronger than in younger people; for example seniors' heart rate rises and stays elevated for a longer time than do younger people's in the same situation. In other words, seniors faced with stressful situations react less quickly but more violently than do younger adults, and their reaction lasts longer. There is, therefore, the potential for increased vulnerability to difficult situations. We must not conclude, however, that seniors are more exposed to the risks associated with anxiety than are other age groups. Human beings are not passive receptors to environmental stimuli. They possess intermediary mechanisms, cognitive or other buffers, which modulate the stress reaction or set compensatory mechanisms into motion.

1.3 Cognitive Component: How Feelings Are Interpreted

Along with the physiological changes due to aging, there are changes in the way people deal with their environment. A person's attitude is more significant than the stressor itself. In fact, the way one copes with stressful situations depends in part on the perception one has of them. Expectations of the situation are crucial. In fact, when organic disorders are eliminated, the elderly are no more at risk of psychiatric disorders or of being more anxious or depressed than their younger counterparts. This confirms the hypothesis that a large proportion of seniors adapt to events rather than developing emotional problems. Some people, however, are more likely than others to experience fear and emotional distress.

1.4 Risk and Protective Factors

Demographically, seniors most at risk of suffering from anxiety are women (particularly widows and divorcees), single men, the socio-economically disadvantaged and those living in institutions. On the psychological level, anxiety is associated with feelings of powerlessness and dissatisfaction with life. It appears that introverted people and those who feel they are manipulated by others are particularly at risk since they have fewer resources to resist stress.

Protective factors are such elements as good health, a structured family support network available if needed, financial security making it possible to live in material comfort even during difficult times, and a healthy and balanced lifestyle.

2. SYMPTOMS OF AND ADAPTATION TO ANXIETY

2.1 Symptoms of Anxiety

Anxiety translates into agitated behaviour, feelings of apprehension and increased preoccupation with physical discomforts. It is important, however, to note that certain conditions such as hypoglycaemia and hyperthyroidism, as well as high coffee intake may cause symptoms that may be mistaken for anxiety.

Psycho-socially, anxiety can be manifested in various ways, such as rigidity in thinking, fear of being alone and suspiciousness of others (Butler & Lewis, 1982). For some, chronic anxiety leads to gastro-intestinal problems, such as heartburn, diarrhea, intestinal spasms and ulcers; in fact, it appears that about half of the cases of gastro-intestinal disorders among persons aged 65+ are of psychological origin (Cohen, 1990).

One very common symptom of anxiety is insomnia which, among seniors, is complicated by normal changes in sleeping habits due to aging and to physiological disturbances independent of sleep (for example, respiratory problems). Naturally, an anxious person whose body is in a state of alert will be more likely to have problems getting a good night's sleep. Thus, when a senior is faced with insomnia stemming from physiological changes compounded by anxiety, he or she may focus on the physical symptom of insomnia rather than on the real source of anxiety. He or she may even attribute increased nervousness to the lack of sleep! According to Cohen (1990), the suddenness of the sleep complaints is a good indicator that the sleep disturbance is due to some degree to anxiety, because the changes in sleep patterns linked to normal aging occur gradually and almost imperceptibly.

2.2 Medicalization of Symptoms

Most seniors prefer focusing on their physical problems rather than on their psychological ones. In fact it has been demonstrated that patients express their distress in a way that is culturally acceptable. It is therefore possible to speculate that the individual is expressing certain psychosocial symptoms in a way that will make them acceptable because, in our society, illness is seen as virtually inevitable once a person reaches a certain age. Symptoms of insomnia and nervousness therefore become "legitimate" and are amalgamated with the physiological problems frequently experienced by seniors, such as osteo-arthritis and cardio-vascular problems. In addition, since medicine is often exclusively concerned with physiological symptoms, it will focus on treating patients with pharmaceutical products. This situation, combined with more frequent use of medical services by seniors compared to the rest of the population, and coupled with their hesitation to call upon psychological services, might contribute to their over-use of mood-altering drugs.

The psychotropic drugs used to treat problems of the central nervous system are often identified as being minor or major tranquillizers, anti-depressants and barbiturates. Minor tranquillizers are the most often prescribed and will be the focus of the current section. According to the Canada Health Survey (1981), seniors over the age of 65, particularly women, are the highest consumers of mood-altering drugs (20 per cent of women and 10.4 per cent of men reported having used these drugs in the two days prior to the survey). It would appear that these drugs are appropriate only for specific situations; for example clinical anxiety (from which only a minority of seniors suffer) or acute crisis situations (and only for periods of not more than a few weeks, with therapeutic interventions of another kind if the symptoms of anxiety persist).

Unfortunately, mood-altering drugs, and particularly minor tranquillizers, are often used continually for several years. This usage is a source of concern because numerous studies have pointed out the **dangers of prolonged use of mood-altering drugs** by seniors. In fact, if there is long-term use, seniors suffer from side-effects such as psychomotor problems, memory loss, decreased lucidity, lethargy and frequent falls resulting in fractures. It should be noted that the side-effects of many drugs are similar to the symptoms of anxiety.

The side-effects are increased by the prolonged use of mood-altering drugs, particularly those which the body has difficulty eliminating. Scientific medical reports recommend that these drugs be used under certain circumstances and that seniors be made aware of possible side-effects or withdrawal problems.

It is therefore crucial to examine the alternatives to what some call "pharmaceutical crutches" or even "chemical straitjackets", which they describe as band-aid solutions. Certain coping techniques or strategies may be used to reduce anxiety levels or to fight insomnia.

2.3 Coping Strategies, or How to Help Oneself

Aging is associated with stresses that can be a fertile ground for anxiety. The sources of stress cannot be altered much, particularly those related to physical limitations, and some are totally related to socio-political priorities. We must, however, never lose sight of the cognitive mechanisms to which we have referred previously. Compensatory mechanisms develop; in particular, people can use techniques aimed at countering the anxiety produced by stressful elements in their lives. For instance, positive comparison with others

of the same age is a source of comfort and helps put things into perspective. Moreover, seniors who draw upon the experience they have accumulated over the years are better able to gain some perspective on the situation. By that very fact, they are able to react less emotionally than can a younger person faced with a given situation for the first time (Schulz, 1985).

People who experience anxiety through sleep disturbance can help themselves (without sedatives) by adopting the following habits (Woodruff-Pak, 1987):

- spend less time in bed; go to bed only when already tired;
- avoid napping during the day and get up at a set time even after a sleepless night;
- take no alcohol, tea or coffee after 6 or 7 p.m. and drink herbal teas or hot milk instead;
- make sleeping conditions as sleep-inducing as possible (noise, comfort, temperature);
- do some physical activity or relaxation during the day.

Some attention should be given to the use of alternatives to medication to deal with everyday problems. The following were the alternatives most often mentioned by respondents to a survey conducted by Pérodeau and Ostoj (1990). All the participants lived in the community and were either independent or becoming increasingly dependent upon caregivers. The

alternatives to drugs used by these people to cope with the problems of everyday life were:

- **recreational activities**: playing cards, seeing friends, reading, listening to the radio, watching television, working with one's hands;
- **non-drug substances**: hot milk and honey, herbal teas;
- **cognitive restructuring**: looking at the problem so as to bring out the positive points or at least the potentially positive points if certain actions are taken;
- **physical activities**: walking, swimming, fitness activities, any sport the individual likes and is able to do;
- **household chores**: housework, minor maintenance;
- **involving others**: confiding in others, discussing problems;
- **getting out**: running errands, eating out;
- **volunteer work**: helping those less well off, babysitting;
- **relaxation or prayer**.

These coping strategies reflect the interests and physical abilities of the participants. Some will be more inclined to turn to family and friends, others will turn inward and seek solitary activities.

Sometimes professional help may be beneficial to the person who cannot master his or her anxiety by self-help strategies. Besides medication, which should be used only in specific cases and only temporarily, there are therapeutic approaches that can alleviate anxiety. Psychodynamic therapy helps the person explore the sources of anxiety in his or her life to help demystify and conquer it. Behaviour therapy can be used to teach relaxation techniques and to make the person less sensitive to the objects or situations that elicit fear. Finally, cognitive therapy will help to show how a person can change his or her ways of thinking so as to make stressful events more manageable.

CONCLUSION

As with any other transition in life, becoming a senior forces the individual to develop his or her own coping strategies for new situations. And, as at every age, most people succeed without too much difficulty in mastering change, while a few are less able to deal with the stress. Moreover, the physiological changes brought on by aging make the organism particularly vulnerable to the effects of stress. Nevertheless, on the whole, seniors do not suffer any more from anxiety than do younger people.

Why is this so? There may be a reason related to sparing effort; anxiety is accompanied by various physiological reactions that greatly tax the body. There might, therefore, be a self-censuring mechanism, a physiological protection, aimed at sparing the individual's physical resources. This is a satisfying but incomplete explanation. The psychological processes that are part of the human experience must also be considered. A person reacts to stress according to his or her personality and past experiences. This latter element is, in fact, one of the advantages of being mature. By the time people reach old age, they have lived through a number of trials and tribulations and

have had to develop strategies to cope with them. More important -- they have survived. Might this not produce "survivors", seasoned warriors? This is all the more applicable to older seniors who are recognized as being less anxious than their younger counterparts, particularly those in their early sixties, who are in a period of transition. This would confirm the importance of the compensatory mechanisms gerontologists associate more and more with normal aging. These mechanisms are related to experience or even to "wisdom".

One of the risks to which the elderly are exposed in stressful situations is to not go beyond the physiological symptom of stress but to deal with it like any other symptom of stress without connecting it with the primary cause. Psychological numbing of the symptom through drug intervention is doubly dangerous because of its physiological and psychological consequences. Symptoms of anxiety, like fever in viral infections, are alarms which signal that the system is in danger; they must not be done away with. If the individual does not identify the source of the problem, the problem might become chronic and create more serious difficulties than those first experienced. For example, gradual deterioration of mental health is one long-term consequence.

Fears and anxiety among seniors, as among any other segment of the population, are signals to which attention must be paid. They reflect difficulties in their lives, but are also the first phase in a process of change better suited to new conditions. Fear and reactional anxiety are normal emotions that are part of human survival equipment. It would be dangerous to annihilate these reflexes artificially when they have been triggered in response to events with potentially harmful effects on the individual's well-being.

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ALCOHOL USE AND ABUSE BY THE ELDERLY

by

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March 1991
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INTRODUCTION

Very early in history, alcoholic beverages were considered to be beneficial for the elderly, either for medicinal purposes or to help seniors forget the sorrows of old age (Mishara & Kastenbaum, 1980). The Bible contains passages recommending the consumption of wine (Proverbs 31:6,7) for those near death and those "of heavy heart": "Let him drink, and forget his poverty, and remember his misery no more."

Although the Bible recommends alcohol to console those who suffer, the negative effects of alcoholic beverages are also recognized. Kings and princes, when under the effects of alcohol (Proverbs 31:5), "forget the law, and pervert the judgment of any of the afflicted." These two views of the effects of alcohol are still prevalent today. Alcohol has positive powers when used in moderation, but becomes dangerous when abused.

1. ALCOHOL CONSUMPTION IN CANADA

Numerous studies, among them the 1981 Health Survey, have shown that seniors are less likely to drink than younger people, and that they suffer less frequently from alcohol-related problems. It has been found, for example, that slightly less than 15% of those in the 65+ age group consume between 1 and 6 drinks per day, compared to slightly more than 20% among all age groups between 15 and 64; approximately 15% of those in the 65+ age group are abstainers, compared to approximately 5% among the 20- to 64- year-olds (McKim & Mishara, 1987). Furthermore, men consume more alcoholic beverages than do women.

There may be several explanations for the data indicating a lower consumption rate among seniors. First of all, the mortality rate is very high

among alcoholics. Persons with alcohol problems, therefore, are less likely to reach an advanced age. A certain "wisdom" (as well as a reduced physical tolerance) may also develop with age, which might explain why a high proportion of seniors reduce their consumption. As one ages, it takes less alcohol to disrupt functioning.

Other hypotheses centre on the differences between generations. In Canada, it is possible that older generations consume less alcohol than do younger generations for various reasons: historical and political factors like the consequences of prohibition in the United States, religious beliefs, or the fact that in their time alcohol played a smaller part in the social and cultural environment than it does today.

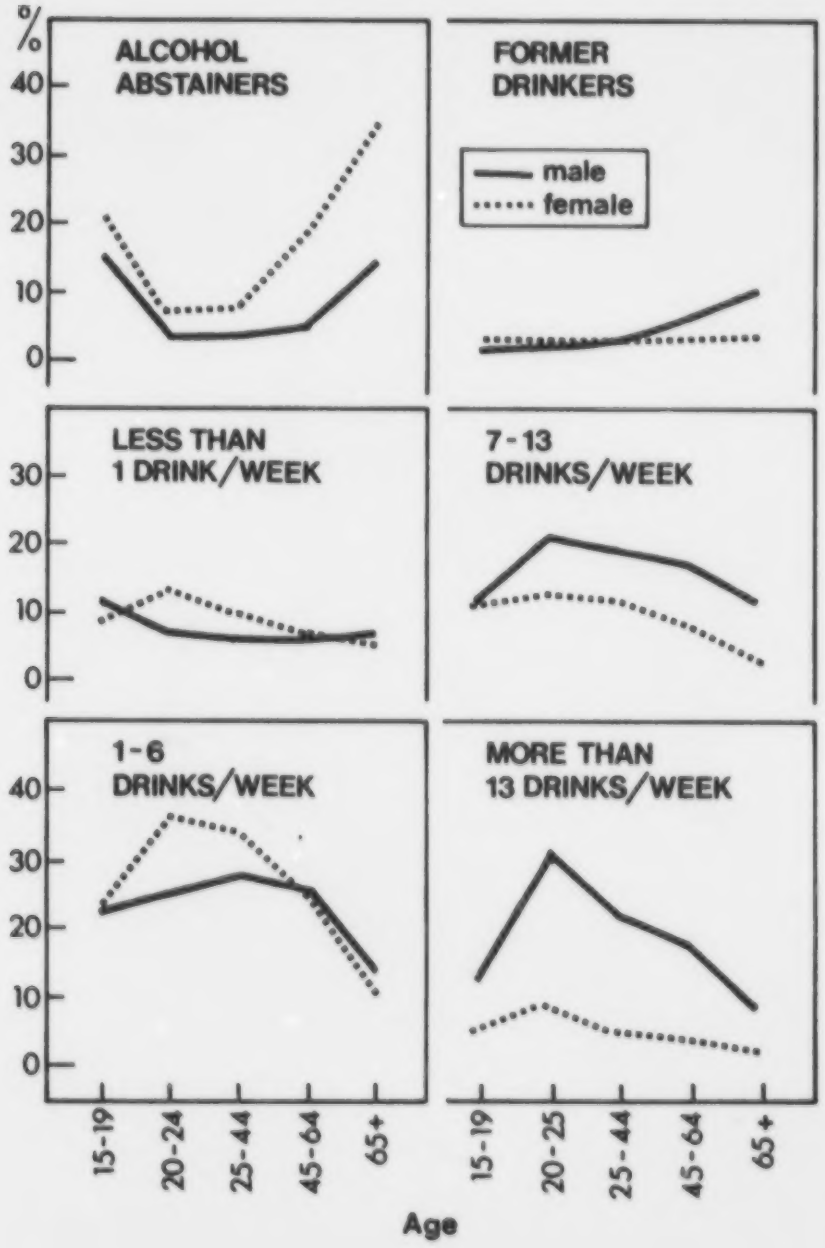
Finally, it is possible that data from studies in which interviewers asked elderly respondents to specify their consumption habits may not be as reliable as those relating to other age groups. Seniors may have a tendency to "forget" (intentionally or not) how much they drink, or may be reluctant to admit it because of a desire to preserve an image of "dignity".

In Canada, there are twice as many female abstainers as male and, in general, women drink less (see Figure 1). These gender differences are comparable to those observed in other countries. It may be, however, that these habits are changing, because there is less difference between men and women in the 15 to 19 age group.

Physiological differences such as weight might partially explain why women drink less. Since they weigh less than men, women need to drink less

FIGURE 1

VARIOUS CATEGORIES OF ALCOHOL CONSUMPTION BY AGE AND SEX IN CANADA



Source: Canada Health Survey, 1981, Table 1, p. 28. Figure excerpted from McKim & Mishara. (1987), p. 66.

to attain the same concentration of alcohol in the blood. However, the data indicate that men drink much more. Taverns and bars where mostly men gather to drink have institutionalized alcohol consumption by men, a phenomenon that might explain the difference between the sexes. It will be interesting to observe the impact of changing sex roles on future drinking patterns, especially of women.

2. PHYSICAL AGING AND ALCOHOL

The response to ingestion of ethanol, the type of alcohol found in alcoholic beverages, varies with age. In general, the absorption of equal quantities of alcohol by two individuals of equal weight, one a senior, the other a younger person, will create a higher concentration of alcohol in the blood of the senior. However, the mechanisms responsible for this higher alcohol level are not clear (Mishara & McKim, 1989; McKim & Mishara, 1987). Age does not seem to have a direct influence on ethanol elimination.

On the other hand, it seems quite plausible that the change in the proportion of body fat to water, which comes with aging, could explain why alcohol consumption affects people differently according to their age. In fact, between age 25 and age 60, the total percentage of body fat in relation to total body weight almost doubles in men and increases by 50% in women. Since alcohol is only distributed to body liquids and not fat, equivalent quantities of ethanol will be more concentrated in the blood of seniors, who have proportionally more body fat. Thus, seniors need to consume less alcohol than do younger and thinner people to feel the same effects.

3. THE EFFECTS OF ALCOHOL

Alcohol has both positive and negative effects. These effects depend on the absorption rate (drinking habits), the social context, expectations, and the presence of illness or chronic disease in the individual.

3.1 Negative Effects

Tolerance to alcohol develops with use, which means that someone who drinks alcoholic beverages regularly over a period of time will need to drink more to achieve the same effect.

The use of alcohol also leads to increased tolerance to other types of drugs. Tolerance to sedatives and hypnotic drugs is especially dangerous. Combining alcohol with other drugs is the most frequent cause of various types of medical crises. Other undesirable reactions include the cross-tolerance which develops when ethanol is consumed along with sedative and hypnotic drugs such as the benzodiazepines (including diazepam, commonly known as Valium) and other minor tranquilizers, anesthetics, morphine and other opioids, certain antidepressants, antihypertensives, anticonvulsants and antibiotics. Furthermore, ethanol can increase the sedative effect of over-the-counter antihistamines and the anti-coagulant effect of Aspirin, resulting in massive gastric hemorrhages in alcoholics.

Excessive consumption is linked to many health disorders. Cirrhosis of the liver and cardio-vascular problems are much more frequent in persons who suffer from chronic alcoholism (Gambert et al., 1984). Alcoholism significantly increases the risk of premature death.

3.2 Positive Effects

Since 1963, several studies have demonstrated the possible benefits of beer and wine served in moderation to seniors, both in institutions and at home. The research mentioned below suggests that a moderate consumption of alcoholic beverages has a positive effect on depression, morale, sleep, and participation of seniors in social activities.

A moderate consumption level of one or two drinks per day seems to reduce the risks of myocardial infarction (Colditz et al., 1985). Moreover, a series of studies (Mishara & Kastenbaum, 1980) to measure the effects of the consumption of one or two glasses of wine per day by seniors living in their own homes showed favourable results. The authors measured the sleep and the cognitive functioning of subjects for 10 days before they started to drink wine, and then compared results with the data obtained following one or several months of consumption. A significant number of seniors said that they had felt an improvement in their sleeping habits, moods and memory. The authors, however, did state that these conclusions would only be valid in the presence of adequate medical controls. They also concluded that moderate consumption of alcohol does not necessarily lead to alcoholism.

Altogether, the research on alcohol and seniors highlights the dual nature of alcohol consumption. Taken in moderation, alcohol presents no threat to health and well-being; it may even increase certain aspects of cognitive functioning. Alcohol abuse, on the other hand, constitutes one of the surest ways of increasing the risks of illness and of premature death.

4. IS ALCOHOLISM AMONG THE ELDERLY UNDERESTIMATED?

There is reason to believe that current data underestimate the number of seniors suffering from alcohol-related problems. In fact, typical symptoms of alcohol consumption are similar to those associated with "natural" aging, such as trembling hands, memory loss, and confusion. Certain health problems can also be falsely associated with aging rather than with excessive consumption of alcohol. Finally, retired and socially isolated individuals tend to drink at home rather than in public; their problems are thus less likely to be noticed (Mishara, 1985). Hidden alcoholism can be a problem especially among women, since it is less socially acceptable for a woman to drink to excess in public.

Researchers agree on the fact that there are two types of senior alcoholics:

- those who became alcoholics at a late age, the «acute» alcoholics ;
- and those who started to have alcohol problems earlier in life and who have survived to an advanced age, the «chronic» alcoholics.

It is estimated that the first group constitutes approximately one third of senior alcoholics. The main factor associated with the development of alcoholism at an advanced age is loss: loss of a spouse, of work upon retirement, of health and physical strength, and loss of a house in the case of a move. Senior alcoholics, as well as their families and friends often deny or refuse to admit that there is a problem. This denial often results in a "tardy referral syndrome" whereby help is sought only once it is absolutely necessary, often due to a medical or social crisis caused or exacerbated by alcohol.

Chronic alcoholics who reach an advanced age comprise two thirds of senior alcoholics. They come into contact with treatment agencies only when their support systems collapse, when they are arrested in a state of intoxication, or when they are admitted to a hospital. Senior alcoholics may also try to be admitted to hospital as a refuge for the winter months.

5. TYPES OF INTERVENTION

Three types of intervention are defined--primary, secondary and tertiary--according to the goals and the clients involved. The goal of **primary** treatment is to stamp out alcoholism before it occurs, through public education and by identifying and treating individuals with a high risk of becoming alcoholics. The **secondary** type of intervention relates to new drinkers; it aims at curing the individual. Various therapeutic models are used: residential or outpatient treatment, professional or volunteer intervention, and group and individual meetings. Effectively curing alcoholism depends partly on early detection; the longer the delay in seeking treatment, the more difficult it is to modify the behaviour. Finally, **tertiary** intervention does not aim at a complete cure but at a reduction of the effects of chronic abuse on the lives of confirmed alcoholics and on society; coercion is usually necessary to force the individual to accept treatment.

Because of the difficulty in getting seniors to admit to alcohol abuse and the social stigma associated with residential treatment in a clinic or treatment centre, a certain number of community-based intervention models have been devised specifically for seniors who have started to abuse alcohol as a way of coping with their difficulties or troubles (Saunders, 1985). Among others, there are the LESA (Lifestyle Enrichment for Senior Adults) program in Ottawa and

the COPA (Community Older Persons Alcohol Project) in Toronto. In general, these community models aim at:

- providing adequate nutrition and any health care needed;
- treating depression when appropriate;
- helping the senior to resolve personal problems without resorting to alcohol;
- developing social relationships;
- providing pleasant and significant leisure activities to replace drinking.

Treatment in a clinical setting consists of detoxification along with the necessary medical care, nutritional therapy to correct deficiencies in diet, and psychotherapy, often in a group situation.

A non-professional support group model which has proven very effective for some people is the Alcoholics Anonymous (AA) organization. Therapeutic elements of AA include the use of alcoholics in long-term remission as role models, the development of support networks, and the teaching of healthy attitudes and adaptation strategies to stress.

With regard to curing alcoholism, senior alcoholics seem to fare better in treatment than younger patients. For example, Linn (1978) found that older alcoholics were more likely than younger patients to remain in treatment. In a five- to eight-year follow-up of treated alcoholics, Helzer et al. (1984), reported a better success rate among seniors than among younger patients. There is no evidence to date that seniors do not benefit from help as much as individuals in younger age groups.

CONCLUSION

Nothing indicates that alcoholic beverages consumed in moderation are harmful; there is, on the other hand, a significant body of research which indicates that moderate consumption of alcohol should be encouraged. People should, however, respect their individual tolerance levels. Alcoholism among seniors, however, demands serious efforts at detection and active intervention. Alcoholism at an advanced age must be considered in light of lifetime habits; different habits require different types of intervention. Although there is certainly a need to develop primary, secondary and tertiary intervention programs, both in institutions and in the community, efforts to develop innovative methods of primary prevention are those which give the greatest hope of reducing alcoholism among seniors.

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SUICIDE AND THE ELDERLY

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March 1991
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INTRODUCTION

People of all ages think about, attempt and die by suicide. This chapter examines the extent and diversity of suicidal behaviour among seniors compared to younger persons, and between men and women 65 years old and over. It also looks at the reasons which motivate some seniors to attempt suicide, the psychological mechanisms and warning signs common in the suicidal individual as well as possible interventions to try preventing suicide. A brief discussion follows about euthanasia and the services available to those who are coping with the suicide of a loved one.

1. NATURE AND PREVALENCE OF SUICIDE AMONG CANADIAN SENIORS

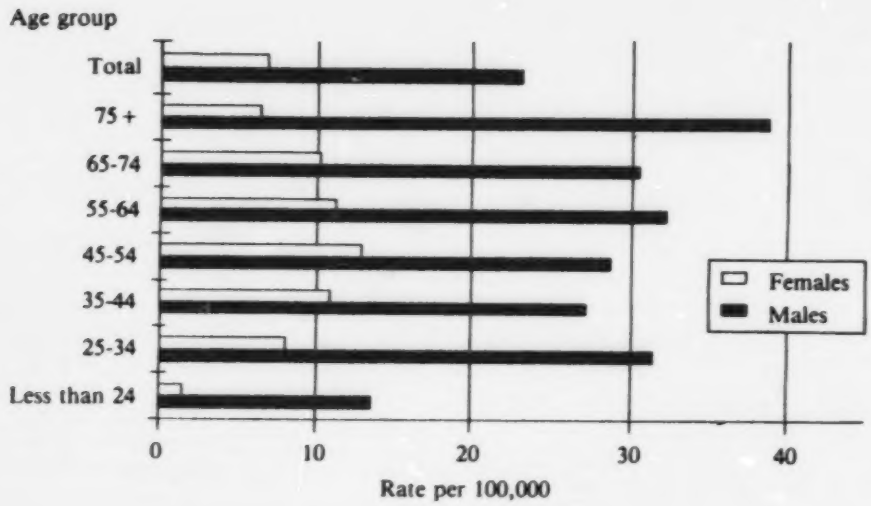
1.1 What Statistics Tell Us

According to statistics published by the Department of National Health and Welfare (1988), suicide rates have generally increased during the past 60 years. The rates of suicide vary markedly according to both age and sex. At all ages, men successfully commit suicide much more often than women, although women attempt suicide more often. Figures released by Statistics Canada (D'Arcy, 1987) show that the highest rates currently occur among men aged 75+. These are shown in Figure 1.

These suicide statistics may in fact underestimate the incidence of suicide among seniors. When a younger person dies from a questionable cause, there is invariably an inquiry from the coroner to determine if suicide is the possible cause. However, in the case of the death of an older adult who may already suffer from many potentially life-threatening diseases, inquiries are less frequent.

FIGURE 1

SUICIDE RATES BY AGE GROUP AND SEX, CANADA, 1983



SOURCE: Statistics Canada, *Causes of Death, 1983*, and *Population Estimates*. Figure excerpted from D'Arcy, C. (1987), p. 436.

Patterns of suicide vary according to age and sex. Among young adults, there are from 50 to 150 suicide attempts for each suicide that results in death. Among seniors, there is a much smaller ratio of attempts to completed suicides, indicating that seniors more often die from their attempts. Men tend to succeed more frequently than women, possibly because men use more lethal means (e.g., firearms) than women (e.g., medication overdose).

As well as suicide attempts, there are numerous behaviours which increase the probability of a premature death, such as not taking required medication, taking risks such as not wearing a seat-belt and not following doctor's orders concerning stress, diet and exercise. These self-injurious behaviours are fairly common among the elderly (Mishara, 1975), particularly among persons who are depressed or unhappy. Besides suicidal or self-

injurious behaviour, many people have, at some point in their daily lives, thought about suicide. Thoughts of self-destruction tend to decrease with age (Quebec Health Survey, 1987).

1.2 Why Do Seniors Attempt and Commit Suicide?

People rarely commit suicide because they want to die, although in some cases, suicide is a way of controlling the circumstances of a death that is already inevitable. People think of taking their own lives as a way of ending depression, unhappiness, loneliness or suffering that they feel is intolerable. People may also kill themselves in a very deliberate way to avoid intolerable degradation or suffering in the future; for example, some persons diagnosed as having terminal cancer or Alzheimer's disease may commit suicide before becoming more physically or mentally incapacitated. The risk of suicide generally diminishes if other options are found to alleviate the person's misery.

The principal risk factors for suicide among older adults are the following (National Task Force on Suicide in Canada, 1987; Templer & Cappelletty, 1986):

- deterioration of physical health;
- increased incidence of mental health problems, notably depression or dementia;
- involuntary retirement;
- death of spouse or other bereavement;
- social isolation;
- loneliness;
- significant financial problems;
- alcohol abuse.

A person who has attempted suicide during a previous life crisis is more likely to try it again than someone who has never been suicidal. The acronym "HHLA" succinctly describes the psychosocial situation of a suicidal person; that is, Hopeless, Helpless, Loss experience and Alone.

1.3 The Suicidal Process

Seniors often deal with problems better than younger persons do because they have more experience handling life difficulties. When faced with a stressful situation, such as the death of a spouse or a painful illness, individuals muster a wide range of coping mechanisms to help them deal with the problem. These may be psychological (e.g., concentrating on something else; seeking counselling to feel better about the situation) or they may involve concrete actions to reduce the suffering (e.g., getting involved in a new activity; seeking medical treatments). If the suffering continues, some people will have a "flash"--they think to themselves that if they were dead, they would not suffer any more. These "flashes" about the possibility of dying or taking one's life as a means of stopping suffering are fairly common. Most people consider the option of suicide at some point in their lives.

If other means of reducing the suffering fail, the idea of committing suicide may appear more frequently. Very often a person will talk about suicide in oblique or in direct ways with others to explore whether or not this option seems possible. A person may say, for instance, "Everybody would be better off if I were dead" or "I am suffering so much that sometimes I think it would be best to end it all".

At this point, the risk of suicide increases as it is considered a possible option. If other options do not work, there is a tendency to focus on suicide as

the best means of diminishing the pain, even to the extent of ignoring other potential solutions which are present. This phenomenon is sometimes referred to as "tunnel vision". At this time, the suicidal individual may tend to search for a method of attempting suicide and begin to plan for it.

No one is completely suicidal. In order to attempt suicide, a person need only be convinced that the option of suicide is the best one at the moment. Despite this conviction, the suicidal individual is always ambivalent, for the will to live and the desire to find other solutions or to continue to tolerate the pain is always present. However, the suicide attempt is the indication that the option of self-inflicted death is stronger than other options at the moment.

Because of this ambivalence, most suicidal persons try directly or indirectly to get help for their problems. Nine out of ten persons who attempt suicide tell another person that they are thinking of killing themselves. The social stigma of talking about suicide may sometimes cause the suicidal person to veil the message, for example, by saying: "I don't think that life is worth living". Suicidal persons talk about their desire to end their lives or hint at it to see if other options present themselves. Owing to the almost universal ambivalence of people who attempt suicide, timely and appropriate interventions are possible.

Some differences have been noted between younger persons and seniors in the psychological antecedents to suicide. According to Templer and Cappelletty (1986, p. 481):

> "In contrast to younger persons, older adults are less likely to have their suicidal act precipitated by a specific, emotionally upsetting event. The suicidal act of an elderly person is more likely to result from the accumulation of events and circumstances over a

prolonged period of time. The suicidal elder will appear more rational and less emotional than a younger person regarding the decision to take his or her own life."

2. SUICIDE INTERVENTION

The ambivalence felt by suicidal persons often leads them to give mixed messages, such as "Don't help me because no one can help me" and "Please help me". For instance, a suicidal senior may call a distress centre or suicide prevention centre to enquire about effective ways of taking one's life. Although the request seems straightforward, the fact that he or she called a mental health resource centre may communicate that part of the person wants help.

After discussion of the caller's problems and desire to die, the helper at the other end of the line would generally find that the focus of the conversation could shift to other, more constructive ways of solving the person's problems.

Successful intervention with suicidal persons does not completely eliminate the idea and the potential for suicide. A successful intervention reinforces that part of the person that wants to find other solutions and facilitates the search for options.

2.1 Suicide Detection

Since most suicidal persons commit suicide after a process of rumination and planning, it is useful for friends, family members and others to be aware of certain signs. The most obvious indication that an individual is contemplating suicide is a remark, such as "Sometimes I think life is not worth living" or "I

would like to just stop taking my medication and die". It is important to be aware of statements such as these and to ask appropriate questions to find out if the person is actually suicidal.

Other signs include "final" preparations such as giving away possessions and making funeral plans. Although it is more natural for seniors to make plans for their own death, often members of the family suspect that the impending death the person is alluding to is not from natural causes. In such instances, questions should be asked concerning the senior's premonition of death or about reasons for making plans at this time.

Very often, suicide attempts occur when someone is depressed. Depression of varying degrees is a common occurrence at all ages. However, when a person is depressed for a long time, or is unusually deeply depressed, it is appropriate to verify if the person is considering suicide.

People often change their personality or behaviour once they have "decided" to end their lives. The thought of ending the pain and suffering by suicide may produce a sense of relief to some, or the anticipation of dying soon may produce marked withdrawal or anxiety in others.

Detecting suicide potential among seniors may be more difficult because they may be less likely to communicate their suicidal intentions, particularly if they are socially isolated (Templer & Cappelletty, 1986). It is, therefore, important to have community outreach services to detect seniors at risk and assist in resolving the underlying problems. Concerned neighbours, landlords, old friends, former work associates and so on, may be able to provide a critical social bridge to seniors at risk.

2.2 But What Can One Do?

Whenever there is a possibility that someone is suicidal, it is advisable to talk with the person directly. Professionals in suicide intervention advise family members, friends and other concerned persons to ask direct and specific questions such as: "Are you thinking of taking your own life?" If the answer is ambiguous or affirmative, additional questions should be asked to determine the risk involved. These questions explore whether the individual has a plan, and what means and time for the suicide are contemplated. Questions such as: "Have you thought about how you might do it? What type of medication are you thinking of taking? Do you have many pain-killers at home? When are you thinking of doing this?" are all useful to determine the extent of the risk. In general, the more detailed the suicide plan, the higher the risk.

Many people shudder at the thought of asking direct questions about suicide. There is a popular misconception that talking about such topics may give people ideas or make them depressed or unhappy. Experience has shown that this is rarely the case. In fact, talking directly about the subject **without moralizing** is one of the most effective means of decreasing the risk of suicide. It is important not to judge the act, not to say that it is right or wrong. It is best to talk about the details and to ask direct questions about the problems in a person's life that lead to thoughts of suicide. The major objective in the helping relationship with a suicidal person is to explore other options besides suicide to end suffering.

Most experts in suicide prevention agree that family members and friends are often the most helpful in reducing suicidal risks. Family and friends of someone considering suicide are encouraged to call a local distress centre or suicide prevention centre for advice on how to help the suicidal

person. Suicide often occurs when someone is in a state of crisis. Because most crises are temporary, the risk of suicide decreases considerably if a concerned friend or family member can help the suicidal person through the critical period.

Because seniors might be less inclined to call a suicide prevention centre than other persons (McIntosh, 1985) other services are required to help suicidal seniors. These services may include befriending or "buddy" systems of telephone calls or visits, which may be done by senior volunteers or senior peer counsellors. Seniors can be employed by suicide prevention centres or distress centres or can act as speakers to seniors' groups and the media (Resnik & Cantor, 1970). Persons who suspect suicide potential in someone they cannot help directly are advised to find other people who can intervene. Ultimately, suicide among seniors can be prevented by alleviating the conditions that lead older people to want to kill themselves.

3. SUICIDE AND EUTHANASIA

Euthanasia, a complex topic, is often misunderstood. The word is of Greek origin and means "a good death". Euthanasia involves at least four types of action or of inaction, for an individual who is terminally ill (Mishara & Riedel, 1985).

Direct and voluntary euthanasia occurs when death is chosen and brought about by the patient. Suicide can be considered direct and voluntary euthanasia. Although most workers in the field of suicide prevention respect the right of an individual to exercise free choice in deciding whether or not to commit suicide, they also know through experience that suicidal persons are almost always ambivalent. Therefore, they do all they can to help the suicidal

person find other options; usually they succeed, but the final decision rests with the individual.

In **indirect and voluntary euthanasia**, an individual authorizes someone else, such as a physician, lawyer or family member to end his or her life in specified situations, such as when the person is comatose or suffering terribly and too confused to make an informed decision. This form of "mercy killing" is quite controversial at this time.

Direct and involuntary euthanasia involves "mercy killing" without the consent of the patient. It implies a direct act that results in death. Examples include unplugging a medical apparatus necessary to keep the person living. Who makes such a decision and under what circumstances is another complicated ethical and legal issue.

Finally, **indirect and involuntary euthanasia** is the concept that is expressed in "living wills" or other advance directives. Here, one specifies that nature should be allowed to follow its course so that a person who would be kept alive only by extraordinary means is allowed to die. Often called "passive euthanasia", this form is usually considered morally acceptable, although the exact means of implementing it are often vague.

4. COPING WITH SUICIDE

The victims of suicide include members of the family and friends of a person who died by suicide. Mourning is always a difficult process, but the pain and suffering of a person grieving a loss from suicide is often much more intense (Emond et al., 1987). In fact, there is a higher risk of suicide among those who lose a close relative by suicide. After a death, there are frequently

feelings of guilt and responsibility, even when the death is from a natural cause. In the case of suicidal deaths, feelings of guilt may reach an intensity that seems intolerable, and it is difficult for most people to admit that the final responsibility for a suicide rested with the person who committed it.

It is usually quite helpful for persons bereaved by suicide to participate in special groups organized by suicide prevention centres or by bereavement support groups. Very often, the bereaved feel that only other persons who have gone through a similar experience can understand the intensity of their anguish. Besides support groups, counselling by mental health professionals can be beneficial in helping suicide survivors deal with guilt and grief.

CONCLUSION

Seniors, especially very elderly men, constitute a high risk group for suicide. There is reason to believe that the official statistics underestimate the true rates of suicidal behaviour among seniors. Learning to recognize common signs and being able to ask direct questions are among the best means of helping suicidal seniors find other solutions to their problems. The belief that seniors have a greater right to commit suicide, or that suicide by seniors is more "justified", not only is demeaning, but also shows ignorance of the evidence that seniors respond as well to suicide intervention as do younger persons.

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MENTAL HEALTH PROBLEMS OF SPECIAL GROUPS

by

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March 1991
National Advisory Council on Aging

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INTRODUCTION

The focus of this final chapter is on the mental health problems experienced by special groups, in particular, aging mentally retarded persons and seniors from ethnic minorities.

1. AGING AND MENTAL RETARDATION

1.1 What Is Mental Retardation?

The diagnosis of mental retardation is made on the basis of performance on intelligence tests. A person of average intelligence has an I.Q. (intelligence quotient) of 100; a mildly retarded individual has an I.Q. ranging from 50 to 70 and a person who is considered severely retarded obtains an I.Q. score of less than 50. Retardation in intellectual functioning occurs before the age of 18 and is typically accompanied by deficiencies in social functioning. As well, mentally retarded persons often have other physical abnormalities, including epilepsy, cerebral palsy, mobility problems or hearing or vision disorders. Because the mentally retarded are so diverse in their functional capacities, the services they require also vary.

1.2 Aging of the Mentally Retarded Population

Like other Canadians, the mentally retarded have a longer life expectancy than ever before. The most recent statistical data indicate that approximately 4 in 1000 over the age of 40 are retarded (Department of National Health and Welfare, 1988). The life expectancy of mentally retarded persons in institutions has increased during the past decade or so (Wolf & Wright, 1987). Because mentally retarded persons age physically earlier than other population groups

and because they have a shorter life-expectancy, they are considered elderly at about age 50 (Seltzer & Krauss, 1987; Howell, 1986).

The aging of mentally retarded persons poses new social challenges. Who will care for those who outlive the caregiving parents? What alternative activities are available to persons with mild to moderate retardation who work in sheltered workshops to enable them to retire from employment? Can retarded persons be integrated into existing programs and services for normal seniors, including residential settings and social and recreational activities? Finally, how can institutions that continue to house the more severely retarded adapt to meet the physical and psychological needs of an older adult population that is gaining in size and importance?

1.3 Different Sub-groups with Special Needs

Mentally retarded seniors form a very diverse group. The severity of their disability, place of residence, social support system and vocational, social and life-skills are some of the differentiating characteristics (Anglin, 1981).

Many mentally retarded adults have lived at home in the care of their parents. When the parents die or become too old and frail to keep caring for their disabled adult child, placement can become a problem. In some cases, a sibling provides shelter and assumes primary care; in others, the mentally retarded adult child will accompany the parent to a seniors' residence or nursing home. Many move to group homes for mentally retarded adults; these individuals may have difficulty adjusting socially to a group home because they have interacted minimally with people other than their immediate families. Moreover, the death or separation from the caregiving parent can be especially traumatic and grief counselling may be necessary.

Other mildly and moderately retarded adults grew up in large institutions from which they were released into the community as the policy of long-term institutionalization for mentally disabled persons was abandoned. Never having had to care for themselves, these individuals may require training in independent living skills, such as simple cooking and cleaning, grocery shopping, taking a bus and budgeting.

A third group, consisting of persons with more retardation or who have physical and mental disabilities, remains in institutions for the mentally retarded. As fewer persons are admitted to large institutions than in the past, the residential population ages. Workers therefore have to learn how to care for residents who experience the physical changes associated with aging and the diseases common in late adulthood.

These distinctions may fade in future years, however, as an increasing proportion of young mildly-to-moderately retarded persons are now living in group homes rather than with their birthparents or in large institutions.

1.4 Services for Older Retarded Adults

Older retarded adults require a range of residential options such as nursing care and support, and with varying degrees of supervision. Options include independent or shared apartment living, group homes, adult foster homes and seniors' residences. Authors such as Anglin (1981) consider that staff working with older retarded adults require gerontological training, and that they need to understand and accept the mental disability and the changes related to age.

For many retarded adults, daily life is structured by employment in a sheltered workshop, where they perform highly structured, routine jobs for pay. The increasing number of older adults in workshops has led to questions about the right to retire and opportunities for a satisfying life in retirement. Survey results (Seltzer & Krauss, 1987) in the United States suggest that retirement options may take the form of community day programs focused on recreational activities offered by the network of services to the mentally retarded or by seniors' programs.

1.5 Mental Health and Retardation

Mentally retarded seniors are vulnerable to emotional difficulties, possibly more so than the general senior population, owing to impaired physical and mental functioning and to unusually stressful developmental experiences (Department of National Health and Welfare, 1988). Loneliness can be a problem for those who have developed few meaningful relationships outside their immediate family and have no friendships with co-workers outside the sheltered workshop. Among individuals who, in addition, suffer from mental illness, it may be more difficult to distinguish symptoms of illnesses such as depression or dementia from the behaviours associated with mental retardation and these persons may not be diagnosed and treated promptly. As well, Alzheimer's disease is more prevalent in older Down's syndrome patients than in the total adult population (Dalton & Crapper-McLachlan, 1984). Finally, some medications taken for several years to control disruptive behaviours, such as aggressiveness or self-mutilation, may cause severe and lasting side-effects (i.e. tardive dyskinesia: repetitive, involuntary movement of facial muscles, the torso or the limbs).

In summary, the needs of aging mentally retarded persons require more attention. As stated by Anglin (1981) in her study of elderly retarded persons in Metro Toronto:

> The need is clear for appropriate organizations to be aware of this "new" area of service demand, to become acquainted with existing programs for senior citizens into which some who are retarded may fit and to begin to develop special services as required.

2. THE MENTAL HEALTH OF ETHNIC SENIORS

According to Milada Disman (1988), ethnicity refers to:

> [...] a sense of peoplehood, shared history, a common place of origin, shared language and so on. Most of all, ethnicity is an intimate dimension of one's mind, consciousness of inner identity. It is the feeling of belonging, based on a shared understanding of life.

Although all of us, in this sense are "ethnics", ethnicity is a salient aspect of life primarily for minority cultural and racial groups. Currently, about 200 000 seniors living in Canada were born in foreign countries (other than Britain or France) and speak one of 15 other languages.

2.1 Problems of Ethnic Seniors

The ethnic senior population is heterogeneous in other respects. Many immigrated to Canada as young adults, have learned at least one official language and have adapted culturally to some extent--men to a larger extent than women because men had more contact through work with Canadian language and culture. Despite the number of years they have spent in Canada,

many ethnic seniors continue to hold on to the traditions and values of their culture of origin.

Others have come to Canada as seniors sponsored by their families with whom they often live. Since the late seventies, about 10 percent of the immigrants were 60 or older when they came to Canada and they generally have less education than immigrants in all other age groups (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). Less educated seniors do not adjust as well as seniors with more education (Dholakia, 1987). They have other serious problems. They may be isolated because they do not speak or read either official language. They may have more difficulty obtaining information, even with material printed in their own language if they are illiterate. Many senior immigrants are also completely dependent on their families financially because they are not eligible for Canadian income security benefits.

The federal government offers language training programs to immigrant seniors through the Department of Immigration. Language skills do not help solve all the problems but they can help alleviate some of them.

2.2 Causes of Stress in Ethnic Seniors

The degree of emotional stress related to "culture shock" experienced by a foreign-born senior varies. It depends on a number of factors, including the degree of similarity between the culture of origin and Canadian culture, the cohesiveness and social support available from the immigrant community and the length of time spent in Canada. Important also is the degree of support the senior receives from his or her family. Because adult children and especially grandchildren often adopt a Canadian lifestyle and values much more readily

than the senior, cultural differences arise within the family, and can lead to conflict and alienation between generations. For example, a report by Dholakia (1987) on the problems of South Asian seniors in Calgary notes that differences in moral, ethical and religious value systems within families are very difficult for them to accept.

Moreover, many come from cultures in which the elderly are held in high esteem and are dismayed by the lack of reverence for old age in North America. The plight of many ethnic seniors is well summarized by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988) in the following statement:

> The loss of what is familiar, and the difficulty in incorporating a new way of life place many elderly immigrants and refugees at high risk for emotional problems and mental disorders. The unexpected loss of status within their own families leads to demoralization. Social and psychological isolation grows as younger members acculturate, and peers, already few in number, die. Unable to adapt, seniors remain alienated from their new environment and may become alienated from their children.

2.3 Mental Illness among Ethnic Seniors

The incidence of mental problems is higher among immigrants than in the native-born population (Disman, 1988) and possibly higher still among immigrant seniors who have few resources to adapt and who are alienated even from their own families and community. A study conducted among Portuguese-born seniors (cited in Disman, 1988) found that depression, anxiety, lower tolerance of stress and physical complaints commonly resulted from social isolation.

An American research report (cited in Disman, 1988) indicates that ethnic seniors are more often placed in mental institutions than native-born seniors, not necessarily because of a diagnosed mental disorder but because they are more difficult for their families and caregivers to deal with.

2.4 Service Provision: A Challenging Context

Appropriate psychological assessment and treatment services are very hard to obtain for the following reasons: cultures differ in the ways emotions are expressed in behaviour; the criteria used to diagnose mental disorders reflect typical behaviours of mentally disturbed persons in North American and Western European cultures; and very few mental health professionals understand the languages spoken by ethnic seniors, much less the ethno-cultural differences in behaviour. Not surprisingly, members of ethnic groups use social and health services less than native-born Canadians (cited in Disman, 1988).

The need for ethnic-specific mental health services has been pointed out in several recent reports (Ontario Advisory Council on Senior Citizens, 1989; Driedger & Chappell, 1987; Disman, 1988). Not only should there be more services designed for and by ethnic communities there should also be sensitive interpretation services within mainstream Canadian services and increased awareness and training of mental health professionals regarding ethno-cultural differences. Another interesting suggestion is to include treatments familiar to ethnic seniors, such as acupuncture and medicinal herbs and foods, within mental health services.

2.5 Avenues for Improvement

Several proposals have been made to ease cultural adjustment and minimize the isolation and social powerlessness that lead to mental problems. Services to prepare immigrants about to leave their country and to ease the transition upon arrival in Canada could be adapted for seniors. Support-groups, language training and activities for immigrant seniors organized by both the general community and ethno-cultural associations are other possibilities.

CONCLUSION

As the number and proportion of seniors in the population increases, the distinct needs of the special groups are emerging. To respond with skill and compassion to their needs is a challenge to mental health professionals.

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